



NEURON CONNECT
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Brain Map Clinical Referral and Order Form Date: _____

Patient Name: _____ DOB: ____/____/____ DOL: ____/____/____
 Patient Phone: _____ Patient Email: _____
 Diagnosis/Current Symptoms/History: _____

 Physician Signature: _____ Phone: _____ Fax: _____
 Print Physician Name: _____ Email: _____
 Attorney: _____ Phone: _____ Email: _____

Order Requested

qEEG Brain Map, diagnostic aide Neurofeedback Therapy Trauma Counseling/EMDR

ICD-10 Diagnostic Codes (check all that apply)

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| <p><u>Mental / Behavioral Health</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> F07.81 – Post Concussive Syndrome <input type="checkbox"/> F32.A – Depression, unspecified <input type="checkbox"/> F41.9 – Anxiety disorder, unspecified <input type="checkbox"/> F43.0 – Acute stress reaction <input type="checkbox"/> F43.10 – Post-traumatic stress disorder <input type="checkbox"/> F43.21 – Adjustment disorder with depressed mood <input type="checkbox"/> F43.22 – Adjustment disorder with anxiety <input type="checkbox"/> F43.23 – Adjst. disorder w/mixed anxiety and depressed mood <p><u>Neurological / Cognitive</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> G31.84 – Mild cognitive impairment <input type="checkbox"/> R41.840 – Attention and concentration deficit <input type="checkbox"/> R41.3 – Memory loss / amnesia <input type="checkbox"/> R41.89 – Other cognitive impairment <input type="checkbox"/> R41.82 – Altered mental status <p><u>Headache / Pain</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> G44.201 – Chronic tension-type headache <input type="checkbox"/> G44.301 – Migraine with aura, not intractable <input type="checkbox"/> G44.309 – Post-traumatic headache <input type="checkbox"/> G44.311 – Migraine with aura, intractable <input type="checkbox"/> G44.319 – Acute post-traumatic headache, not intractable <input type="checkbox"/> R51.9 – Headache, unspecified <input type="checkbox"/> M54.2 – Cervicalgia <input type="checkbox"/> Other _____ - _____ | <p><u>Vestibular / Sensory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> R42 – Dizziness / giddiness <input type="checkbox"/> H81.10 – Vertigo <input type="checkbox"/> H53.14 – Photophobia <input type="checkbox"/> H53.9 – Visual disturbance <input type="checkbox"/> H93.19 – Tinnitus <input type="checkbox"/> H93.23 – Hyperacusis <p><u>Somatic / Other Symptoms</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> R11.0 – Nausea <input type="checkbox"/> R11.2 – Nausea with vomiting <input type="checkbox"/> R20.2 – Paresthesia <input type="checkbox"/> R26.81 – Unsteadiness on feet <input type="checkbox"/> R53.83 – Fatigue / lethargy <input type="checkbox"/> R45.1 – Restlessness / agitation <p><u>Traumatic Brain Injury / Concussion</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> S06.0X0A – Concussion w/out loss of consciousness <input type="checkbox"/> S06.0X1A – LOC ≤30 minutes <input type="checkbox"/> S06.0X2A – LOC 31–59 minutes <input type="checkbox"/> S06.0X3A – LOC 1–24 hours <input type="checkbox"/> S06.0X4A – LOC >24 hrs (returned to baseline) <input type="checkbox"/> S06.0X5A – LOC >24 hrs (no return to baseline) <input type="checkbox"/> S06.0X9A – LOC unspecified <p><u>History / External Cause (if applicable)</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Z87.820 – History of traumatic brain injury <input type="checkbox"/> V49.50XD – MVA, subsequent encounter |
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